



STATE HEALTH OPERATIONS CENTER STATUS REPORT QUESTIONARRE

DATE	
PROVIDER NAME	
LICENSE ID	
PROVIDER TYPE	(i.e. skilled nursing facility, assisted living facility, adult day care center, ambulatory surgical center, etc.)

ADDRESS		COUNTY <input type="checkbox"/> NEW CASTLE <input type="checkbox"/> KENT <input type="checkbox"/> SUSSEX
CITY		ZIP CODE
STATE		TELEPHONE
CONTACT PERSON	NAME	E-MAIL

NOVEL CORONAVIRUS (COVID-19) RELATED INFORMATION:

INFORMATION REQUESTED	ANSWER	COMMENT/ADDITIONAL INFORMATION
LICENSED BED CAPACITY		
CURRENT CENSUS		
AVAILABLE BEDS FOR SURGE		
AVAILABLE SPACE FOR SURGE		
ARE THERE ANY CONFIRMED COVID-19 POSITIVE RESIDENTS?	<input type="checkbox"/> Y <input type="checkbox"/> N	IF YES, HOW MANY?
ARE THERE ANY RESIDENTS WITH COVID-19 SYMPTOMS?	<input type="checkbox"/> Y <input type="checkbox"/> N	IF YES, HOW MANY?
HOW MANY SYMPTOMATIC PATIENTS HAVE BEEN TESTED FOR COVID-19?		
EMERGENCY OPERATIONS ACTIVATES	<input type="checkbox"/> Y <input type="checkbox"/> N	
IMPLEMENTING VISITOR RESTRICTIONS	<input type="checkbox"/> Y <input type="checkbox"/> N	
STAFFING SHORTAGES	<input type="checkbox"/> Y <input type="checkbox"/> N	
MEDICAL SUPPLY SHORTAGE (i.e. PPE)	<input type="checkbox"/> Y <input type="checkbox"/> N	
SUPPLY REQUEST FORM SUBMITTED TO OFFICE OF EMERGENCY MEDICAL SERVICES	<input type="checkbox"/> Y <input type="checkbox"/> N	

ADDITIONAL NOTES: